Treatment Plan
Agency Name
Agency Address

Identifying Information
Name: Age:
Client ID: Gender:
Parent or Legal Guardian:
Individual(s) present:

Service Rendered: Treatment Plan
Setting of Service:
Start Time: End Time: Duration:
Service Provider:

Statement of disability and need for mental health therapy:
Based on mental health assessment results

Treatment Goal One:
Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Treatment Goal Two:
Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Treatment Goal Three:

Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Treatment Goal Four:
Identify specific treatment goal based upon assessment results
Specify SMART objectives related to achieving the treatment goal
Treatment Method:
Individual, family, or group therapy
Therapeutic Modality:
DBT, CBT, EMDR
Frequency and Duration of treatment:
Weekly sessions of 60 minutes duration
Treatment Review or resolved Date:
Date treatment goal is reviewed or resolved

Discharge Plan:
Describe discharge criteria related to the treatment goals/objectives
Describe tentative discharge plans
Identify community resources needed to implement the plans

I have reviewed the treatment plan with the client: Y /N

Client Signature: Date:

Parent Signature: Date:

Licensed Therapist Signature: Date:
Include credential and title

Clinical Supervisor Signature: Date:
Include credential and title
(If necessary)